# Collateral issues in times of covid-19

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**Observações do avaliador:**

**1. Os pontos para serem revisto pelos autores estão de vermelho.**

**2. Nota-se claramente que o inglês usado é o britânico, o qual predomina o uso de letra S nas palavras como *normalising, minimising, practicing, emphasises, banalisation*, entre outras e o uso da letra U em *neighbour* e *behaviour.* Não obstante, foi tomada a liberdade para apontar no texto, meramente como sugestão, para o uso da grafia do inglês americano para tais palavras, no qual a letra Z é utilizada no lugar do S e o U é omitido.**

**TOPIC: ETHICS; LITERATURE REVIEW**

# TITLE: COLLATERAL ISSUES IN TIMES OF COVID-19: CHILD ABUSE, DOMESTIC VIOLENCE AND FEMICIDE

# *QUESTÕES COLATERAIS EM TEMPOS DE COVID-19: ABUSO INFANTIL, VIOLÊNCIA DOMÉSTICA E FEMICÍDIO*

## Abstract

Worldwide there is evidence of the increase of violence against women (gender-based) and children (gender and age-based) during the global pandemic of COVID-19. This literature review offers an overview of data on domestic and intimate partner violence (IPV) as it currently stands in some countries during the pandemic, describing deep psychosocial issues that illustrate the intergenerational transmission of violent actions, uncovering how these acts are unconsciously reproduced within families as a lack of conscious differentiation between them and the cultural, socio-economic norms that surround them takes place, as if normalising (normalizing) the brutality of gender inequality [violence as a representation of masculinity], minimising (minimizing) the effects of witnessing to violence, and/or practising (practicing) violence as a form of discipline. Furthermore, it also includes recommendations that aim to mitigate risks and consequences of violence, and emphasises (emphasizes) the urgency that must be in place to guarantee public access to health care services adapted to our new reality / COVID-19. In conclusion, we accentuate that the

pandemic might accelerate public measures on decision making that target vulnerable women and children and make them regular in case they are judged efficient in face of an ever-growing phenomenon, that is the unfortunate banalisation (banalization) of violent acts and narratives.

## Resumo

Em todo o mundo, há evidências do aumento da violência contra mulheres (com base no gênero) e crianças (com base no gênero e na idade) durante a pandemia global do COVID-19. Esta revisão de literatura oferece uma visão geral dos dados sobre violência doméstica e violência por parceiro íntimo (VPI), como ocorre atualmente em alguns países durante a pandemia, descrevendo questões psicossociais profundas que ilustram a transmissão intergeracional de ações violentas, revelando como esses atos são inconscientemente reproduzidos nas famílias como uma falta de diferenciação das consciências entre elas e as normas socioeconômicas culturais que as cercam, como se normalizando a brutalidade da desigualdade de gênero [a violência como representação da masculinidade], minimizando os efeitos de testemunhar a violência e / ou praticar a violência como forma de disciplina. Além disso, inclui recomendações que visam mitigar riscos e conseqüências da violência e enfatizar a urgência que deve existir para garantir o acesso público a serviços de saúde adaptados à nossa nova realidade / COVID-19. Concluindo, acentuamos que a pandemia pode acelerar as medidas públicas de tomada de decisão que visam mulheres e crianças vulneráveis e regularizá-las caso sejam julgadas eficientes diante de um fenômeno cada vez maior, que é a infeliz banalização de atos e narrativas violentas.

**Keywords**: femicide, COVID-19, intimate partner violence, child abuse, victimisation (victimization), bidirectional violence

**Palavras-chave**: femicídio, COVID-19, violência por parceiro íntimo, abuso infantil, vitimização, violência bidirecional

## Introduction

In times of outbreak of the pandemic COVID-19 that has require(d) quarantine and social isolation, for many women and children, the threat seems greater where they should be safer: in their own homes. The pandemic has increased the abuse in almost all countries[1,2]; however, even before that, a third of women worldwide experienced some form of violence[3]. Additionally, data from 2015 had showed that one billion individuals aged 2–17 years have experienced physical, sexual, or emotional violence, or neglect[4], what is alarming, in considering that currently people under 18 years of age compose over a quarter of the world population (29.3%, thus approximately 2.2 billion individuals[5]), meaning that around half of the total of this population is victim of these types of violence.

In this sense, this literature review aims to discuss issues that have been poorly addressed by researchers, politicians, and other members of the crisis committees on repercussions of social distancing in interpersonal relationships. Concomitantly (*substituir por* At the same time), it emphasises (emphasizes) that more consistent actions and planning for joint solutions between social actors from statutory, private, voluntary, and informal sectors that act within the healthcare and welfare systems must be developed, implemented, and maintained to tackle and reduce the rates of violence against women and children, in a way that is capable to pedagogically and ethically sensibilize all citizens to understand (*substituir por* to raise citizens awareness) that minimizing violence is a duty for each and every person, at all times. This literature review does it by arguing that our social interconnectedness, be it allowed to happen or not, (remover) is marked by violent

interactions, hence, accentuating that these expressions must not be taken as something that results from a challenging period for human coexistence / COVID-19, but something that is ingrained, as if permanently, in individual and collective ways of relating, that must be desperately curbed, and transformed.

"Femicide" or "feminicide" is becoming recognized worldwide as the ultimate manifestation of violence against women and girls[6] and cannot be seen as only occurring in misogynist cultures as a form of gender-based violence, for it is necessary to expand the understanding of the problem by drawing attention to the colonial origins of the patriarchs[7], expanding the observers' comprehension to realise (realize) that these dynamics in developing cultures are also somehow an unfortunate socio-cultural inheritance of more developed countries [in which these practices can still be active], that by force and coercion, that is, by active and domineering power struggles, conquered, extracted, and dominated the occupied territories, what makes this phenomenon also translocal. The theoretical term femicide emerged in England in 1801 and was popularized almost two centuries later by Diana E.H. Russell at the International Tribunal on Crimes Against Women in 1976 in order to name the intentional 'killings of females by males because they are females'[8,9]. Intimate Partner Violence (IPV, henceforth remover *henceforth*), a phenomenon intrinsically connected to the practice of femicide, is defined as a physical, sexual, psychological, and/or economic violence that occurs between former or current intimate partners[10].

To prevent and combat gender-based violence during the pandemic worldwide, the United Nations Organisation (REMOVER - Organization) (UNO, henceforth) (Trocar UNO por UN e remover *henceforth*) recommends more investment in online services and in civil society organizations; ensuring that judicial systems continue to prosecute aggressors and establishing emergency alert systems in public places. In this context, first responders need to be informed about increased risk and options for intervention and should be offered adequate support in coping with their own traumatic experiences caring for severely ill patients and a rising number of patients exposed to IPV[10]; unfortunately, there is a shortage of shelters for victims of domestic violence because of conversion into health facilities or measures to contain the spreading of COVID-19; some are closed whilst others are full.

Furthermore, domestic violence is a worldwide public health problem that can be defined as ‘any incident of threatening behavior, violence (psychological, physical, sexual, financial, emotional), or abuse between adults who are or have been an intimate partner or family member, regardless of gender or sexuality’[11]. It is in analysing (substituir por *Analyzing*) domestic violence that (remover) we can understand how violence against women and violence against children intersect in many ways. The lockdown has been subjecting vulnerable children and adolescents to an extended period of family contact which sets up perfect conditions for an external safeguarding failure in cases in which children are [already or to become] victims or witnesses to domestic violence, being surrounded by incidents or pattern of incidents of controlling, coercive, threatening behaviour (behavior), severe discipline, or suffer from chronic neglect (medical, nutritional, emotional, educational, and supervisory). Therefore, there is this, ‘imposed by salutary need’, lack of regular access to professionals such as teachers, general practitioners, health visitors, and social and/or youth workers, who are external agents that can act as sources of support and provide routine opportunities to detect signs and/or narratives that activate safeguarding concern[12].

As exposed by the essay of Klevens and Ports (2017)[13] in citing two studies that used Multiple Indicator Cluster Survey (MICS) data from 25 middle and lower income countries ‘caregiver reported child physical and psychological abuse was higher in countries where violence in families was more of a cultural norm (i.e., they reported greater acceptance of corporal punishment and intimate partner violence)[14] and in countries with lower levels of education (p. 3)[15]. In relation to the gender of the victims, the study of Edinburgh, Saewyc, and Levitt (2006)[16] pointed out that girls are at increased risk of suffering from sexual abuse and the research of Thompson, Kingree, and Desai, (2004)[17] reports that boys are more likely to experience physical abuse. According to the research of Stöckl et al. (2017)[18] which studied data from 35 countries and aimed to describe the profile of child homicide perpetrators, ‘more than half (median percentage 56.5, IQR 23.7–69.6) were murdered by a parent, 3.0% (IQR 0.0–7.1) by another family member, 12.6% (5.–31.3) by an acquaintance, for example, a neighbour (neighbor) or friends, 2.1% (0.0–11.1) by a stranger and perpetrator remained unknown for 9.2% (0.0–21.9)’ (p. 4).

In generally discussing the impact of the COVID-19 upon the lives of women who are victims of domestic violence is important to hold in mind that a portion of this population is already subjected to a veiled and unspoken lockdown, as the study of Rees, Agnew-Davies and Barkham (2006)[19] affirms them to be constantly exposed to controlling behaviours (behaviors) which involve their repeated sexual assault, the monitored use of their time, the prohibition from seeing their extended family, and/or close friends, being that many of them are not allowed to work, or to leave house under any circumstances, suffering the risk of being harassed or stalked in case they do. Similarly, in observing the impact of the COVID-19 lockdown upon the individualities of children who are physically and/or sexually abused by parents and/or caregivers it cannot be forgotten that the former, depending on their ages, developmental stages, and levels of self-agency may have not sufficiently developed cognitive skills or emotional capacity to identify and process the unspeakable and inimaginable (unimaginable) violation that composes the acts and words they are subjected to, for they are thoroughly immersed into this perverse reality as family-members who depend upon parents/caregivers for their own survival. Hence, they might be affectively and cognitively unable to decodify the gravity of their circumstances in a way that would make them capable of reaching out for help, for they cannot comprehend and elaborate by themselves, in their here-now, that they are victims of crimes.

It is by understanding these specific particularities of both these populations, that is, the psychophysical 'imprisonment' in which they already live their day-to-day lives, that their psychophysical realities must be comprehended as if:

A) In case of women, they could be unconsciously 'accustomed' to these violations by having unjustly suffered regular exposure to them, for they probably were previously and maybe continuously victims of many forms of violence (before suffering it from their intimate partners) and, as a survival and/or maladaptive coping mechanism justified the performance of violence by others as if an 'acceptable' aspect of reality [e.g. they *distortedly and most wrongly* might believe that they deserve the reproduction of these conditions in their bodies and minds] and/or 'unchangeable' aspect of living [e.g. they might believe and/or know for a fact that their pain reflects the pain of so many other women like them (grandmothers, mothers, friends, etc.)], not gathering, hence, enough ego resources to fight

against the *abnormality and criminality of these abusive acts*, for in their signified comprehension they represent a collective illness, that is, something stronger and more permanent than that what the personal individual, *as one individual*, is capable of confronting, meaning that, in this state of isolation and conditioned cognitive impairment they do not see a way out of it [they cannot formulate a strategic confrontation by themselves, or cannot strongly foresee that the extinction of this suffering is possible].

B) In case of children, they could be consciously unaware of the full *conceptual meaning* of abuse, humiliation, and subjugation that they are subjected to within the dysfunctional dynamics in which they exist, as younger, physically weaker, and cognitively, for developmental reasons, unable to process that the occurrences that characterise (characterize) their family environment [for constantly repeated] are, without questioning, violating their right to develop and grow into adult individuals who ideally do not present intrapsychic difficulties that can culminate in behavioural (behavioral) disorders which will accompany them throughout their lifespans, if kept unattended.

Sadly, both responses that are commonly taken by women and children who are victims of abuse demonstrate and highlight that violence occurs cyclically, that is, those who are victims of it can socio-culturally blamelessly or wrongly normalise (normalize), naturalise (naturalize) the expression of the same, and become either permanent victims or perpetrators of it, the latter as the reverberation of a psychic faulty coping mechanism that, in a deeply distorted manner, aims to regain or experience the power that could not have been reactively shown in face of the abusers who initiated the chain of humiliation, helplessness, and hurt which primarily touched the development of their personalities.

In addition, it is fundamental to remember that, individually, without the aid of community spaces, that is, places in which the victim shares her/his struggles with close friends, other family members, and/or support groups, she/he is isolated, anxious, ashamed, unaware of the unhealthy levels of jealousy, control, surveillance, and externally imposed limits to her/his expressions, choices, and freedoms, what prevents her/him from breaking this cycle. For this reason, considering the frequency in which violence occurs in our world is that all individuals of any society must make themselves receptive and ready to empathically listen to the disclosure of these contents when they surge, and be prepared to

efficiently signpost to survivors the ways in which they can obtain the expert help they so desperately need.

In this sense, in attentively understanding the transmissible gravity of the phenomenon of violence that we, as health professionals, be our expertise more closely related to the body or the mind of our clients/patients, must perform an even more serious commitment to having and sharing this personal, global, and collective responsibility of ethically identifying, reporting, analysing (analyzing), and intervening *as soon as we can* when there is the sound suspicion and/or the concrete evidences that some form of violence is touching the individuality of those who we serve[1].

The current response to the pandemic has forced the development of strategic relationships, policy reforms and new practices that will accelerate the integration of care and redesign of the preventive and protective measures that vulnerable women and children need and are long overdue. This redesign requires the determination of which strategies efficiently work and, hence, can be continued as part of routine care (e.g. extended telehealth and/or advice lines, which offer Live Chats with formally skilled professionals and/or members of the community that were purposefully prepared for this interaction; online, but official channels - websites - for the receipt of confidential reports, or the offering of access to multidisciplinary support; the creation and divulgation of survivors' forums, which are anonymous and virtual spaces for women (over 18) who have suffered from domestic abuse to share their negative and positive experiences and support one another, etc.). Existing learning networks for transforming healthcare can play a pioneering role in making recommendations that will enable society to offer better integrated care in the future for all vulnerable individuals at risk of maltreatment during the pandemic[20-22].

However, in spite of all these intentions and planifications (remover), it is also necessary to consider the mental health state of the medical, clinical, social, psychological answering services, and the police forces responding to the increase in violence triggered by

[1] More information on this topic, that is, in how to holistically and responsibly approach psychophysical cues that indicate that something of a coercive and/or violent order is happening to a patient/client is shared in section '3' of this writing.

the COVID-19 lockdown. Health professionals and the police are overworked, and understaffed, local support groups are either paralyzed or financially deprived. Dentists, who are in a unique position to spot signs of physical abuse because oral or facial trauma occurs in about 50% of physically abused children, and lips are the most common site for inflicted oral injuries (54%) followed by the oral mucosa, teeth, gingiva, and tongue[23]; unfortunately, due to the characteristics of dental settings, are afraid or unable to work[2] because the risk of cross infection can be high between patients and dental practitioners.

**Worldwide context**

The 'violence' phenomenon is sociocultural, involves hierarchical and/or imbalanced relationships of power in which the doer of the violence has an idea, a fantasy and/or the empirical possibility of being in a position of authority over the abused individual, thus, it is a question that perpasses (substituir por *relates to*) gender, economical, generational, and ethnical issues. World Health Organization (WHO, henceforth) (remover *henceforth*) research detailed the disturbing impacts of violence on women's physical, sexual, reproductive and mental health[21]. Women who experience physical or sexual abuse are twice as likely to have an abortion, and the experience almost doubles their likelihood of falling into depression. In some regions, sexually assaulted women are 1.5 times more likely to acquire HIV, and 2.3 times more likely to present alcohol addiction. In 2017, more than 87,000 women were intentionally murdered, being members of their own nuclear families or their partners the perpetrators of these crimes in more than half of the cases. Gender-based violence is as serious a cause of death and disability among women of reproductive age as cancer, and a greater cause of health problems than traffic accidents and malaria combined[22].

Despite the high prevalence or widespread prevalence of femicide, only a few countries have specific registries about this issue. Countries like Colombia, Argentina and Peru have reinforced the established aid lines. In Chile, the Ministry of Women and Gender Equity has launched a specific contingency plan for victims[25]. According to the UNO (substituir por *UN)*, the number of calls received by helplines who serve women victims of

[2] Effective infection control protocols are urgently needed in dental practices24 Meng, L., Hua, F. & Bian, Z. Coronavirus Disease 2019 (COVID-19): Emerging and Future Challenges for Dental and Oral Medicine. *Journal of dental research* **99**, 481-487, doi:10.1177/0022034520914246 (2020). (Meng et al., 2020).

violence doubled, compared to the same month last year in Lebanon and Malaysia; in China they have tripled; and in Australia, Google recorded the highest number of searches for the term "domestic violence" in the past five years. These numbers give an indication of the scale of the problem, but only cover countries where information systems exist[26]. In the following paragraphs we provide some general and up-to-date information on the increase of violence against women and children around the world, triggered by the enforced lockdown.

*Brazil*

In Brazil, the maltreatment of children and adolescents (substituir por *child and adolescent abuse*) has been recognized as a serious public health problem[27]. Previous studies addressing child neglect and abuse by parents verified that the number of incidents of psychological and physical violence is still high[28-30]. An increase of sexual violence against children up to 9 years old was found, being from 4.684 (2010) to 9.673 notified cases (2016). Sexual victimisation (victimization) of babies younger than 1 year old increased by 40% in the last years, and that, although girls are still the majority of the population affected by this crime, the number of boys who were sexually abused increased by 93% between the years of 2010 and 2016.[31]

The 'Maria da Penha Law' (Brazil's Federal Law 11340) aims to prevent domestic and family violence against women and its impact is observed in urban areas. In rural area this replication of positive impact becomes more difficult, because the countryside needs both to receive strategic support from the government - federally - and to locally and proactively commit itself to approach the minimisation (minimization) of domestic violence as a high priority in its ethical agenda[32].

*Argentina*

Since the beginning of the compulsory isolation, there have been 23 femicides which means that a woman dies every 32 hours in the country. In addition, in 72% of the cases the woman victim was murdered at home and her victimizer was a person from her inner circle. Also, a 39% increase in calls for gender violence has been reported[33]. Moreover, Argentina's mandatory confinement is a threat to children and adolescents. Different organizations warn

that the situation of confinement creates extraordinary tensions that promote violence against children, even in homes without a previous record. The loss of work, the study at home, the lack of money, the alteration of already settled routines and, above all, the enforced coexistence within the family environment without a provisional distancing from it can contribute for unprepared and/or psychologically challenged parents and/or caregivers to release the accumulation of their many tensions upon the most vulnerable social actors of the family, that is, children. Without physical and/or verbal capacities [remembering that infants are preverbal, immobile] and developed enough ego-resources to defend themselves, children are the biggest victims of confinement[34].

*Mexico*

According to official figures, police complaints about domestic violence increased about a quarter when comparing March/2020 with the same period last year. Since the lockdown, there has been an increase in reports of domestic violence, many of them psychological violence. In Mexico, the emergence of femicide is inextricably linked to the intersection of structural reforms enacted since the 1970s, escalating levels of violence associated with the drug war, and historically entrenched inequalities of gender, race, and class[35]. Furthermore, the United Nations Children's Fund (UNICEF) denounced an increase in violence against children in Mexico during the COVID-19 pandemic and urged the Mexican authorities to strengthen child protection. Six out of 10 children between the ages of 1 and 14 have suffered "violent discipline" at the family level, a situation now aggravated by confinement. There was also an increase in emergency calls for abuse, harassment, rape, intimate partner violence or family violence during quarantine[36].

*Africa*

Evidence from Kenya, South Africa and Uganda demonstrate increase in the prevalence of domestic, sexual, and other types of violence against women and children. Restrictions of movement, lockdowns with widespread socio-economic fallout and business slowing to a near halt have been causing more cases of gender related violence which requires urgent attention regarding prevention and response[37]. Increased rates of abuse and exploitation of children have occurred during previous public health emergencies, for

instance, school closures during the outbreak of Ebola virus disease in West Africa from 2014 to 2016 contributed to peaks in child labor, neglect, sexual abuse and teenage pregnancies. In Sierra Leone, cases of teenage pregnancy more than doubled to 14,000 from before the outbreak[38].

*United Kingdom*

The latest femicide census report released in February 2020 informed that 149 women were killed by 147 men in 2018. This has increased by 10 deaths from their last report in 2017[39]. A campaigner, Karen Ingala Smith, recently stated that domestic violence killings appear to have more than doubled during the coronavirus lockdown, citing that at least 16 suspected domestic abuse killings occurred between 23 March and 12 April 2020. It seems that the lockdown has created conditions which give men excuses and additional triggers (Independent, 2020). There has been an almost 20% rise in calls to the National Society for the Prevention of Cruelty to Children (NSPCC) since the start of the COVID-19 lockdown from adults concerned about child abuse, including neighbour (neighbors), extended family or delivery drivers[40].

*USA*

Sexual assault and intimate partner violence are common in the USA, and they often co-occur[41]. According to the Centers for Disease Control (CDC) and Prevention, 1 in 3 women and 1 in 4 men have experienced violence from an intimate partner in their lifetime and the risks to victims are severe. About 41% and 14% of female and male intimate partner violence survivors respectively sustain a physical injury from their abusers, and about 1 in 6 homicide victims are killed by their intimate partners. Alcohol abuse has been linked to an accumulation of stressful events with bars and restaurants being limited to take-out service as a result of COVID-19. Also, reports of increasing gun and ammunition sales during the crisis are particularly concerning given the clear link with fatal domestic violence incidents. The mass release of prisoners to reduce their risk of spreading COVID-19 in confinement must also weigh the potentially significant risk for households if violent offenders are among those released[3]. Additionally, given the high prevalence of child abuse and neglect and its vast consequences, the associated economic impact is substantial. In the US, the total lifetime

economic burden associated with child abuse and neglect[3] was approximately $124 billion in 2008[42].

**Psychological aspects of domestic violence**

It is important to understand that in preventative strategies that aim to curb the phenomenon of violence and abuse against any population, the WHO recommends, as a reference for the elaboration of strategic measures and their posterior application, the theoretical and methodological knowledge that derives from the 'bioecological model of human development'[43,44]. This model aims to exert a holistic understanding of this phenomenon, in which is intended the broad analysis of how many different variables in a context interact. In speaking of the nature of relationship of these interactions, more than ever it must be emphasised (emphasized) that they should be analysed (analyzed) as if occurring in linear and non-linear points of relation, in which each point [variable] should be seen as also capable of engaging in an oscillation of amplitude and frequency with another point independently of the initial conditions that created their interaction.

In practical terms, while intelligently approaching the characteristics of both victims and perpetrators of violence, the professional who interrelates with them should be informed of: their age, racial/ethnical makeup, gender, marital status, migrant status (refugee or immigrant), income (and if there is a financial dependence in place between both, or whether they are supported by the receival of statutory benefits), educational level, religious practices, history of employment, previous mental health diagnosis, demographics for the region in which they inhabit [considering also their living arrangements, that is, who are the individuals that co-exist in their houses], level of intimacy of their relationship; nature, frequency, and degree of the acts of violence; the cultural norms and/or taboos that surround their existence, and, in case the perpetrator is an officially known offender, the analysis of the number of complaints received against him/her by the police force, their seriousness, and the penalties issued. Having access to this complex and multiple data, the attention of the professional then must be directed towards richly integrating how individual characteristics of victims and

[3] These costs are associated with maintaining children supported in out-of-home care, affording the expenses related to the lost productivity resulting from victims' reduced phychophysical functional capacity, and costs of social welfare (Widom, 2014).

perpetrators, aspects of their family environment (their family of origin, and the family they constituted, in case they are family-related) united to the socio-cultural and economic networks that circumambulate them tolerate, stimulate, condemn, or confront the practice of violence.

Thus, in the context of safeguarding women, the vulnerability of the adult at risk is related to how able she is to make and exercise her own informed choices free from duress, and to protect herself from abuse, neglect and/or exploitation. However, vulnerability should be seen as a continuum – in an approach that reflects the shifting nature of vulnerability, in the sense that diverse levels, conditions, contextualisation (contextualization), and relativisation (relativization) of vulnerabilities must be observed, stimulating the perceptual awareness of health professionals to identify the potential of acquired vulnerability that is due to wider, collective circumstances, also seen in terms of time-space – in that a woman can be temporarily vulnerable. In this way, vulnerability is not centred (centered) only in the analysis of certain characteristics of the individual (e.g.: her age, or whether she is diagnosed as suffering from some mental disorder, and/or a disability) but also in comprehending her environmental situatedness, that is, the more or less stable affective quality of the interrelationships in which she is immersed and/or engages, as an agent and receiver of actions and narratives.

It also may be taken into consideration, as accentuated by Ulloa & Hammett (2016)[45] that the vulnerable woman who suffers from IPV is not necessarily only a victim of violence, but she can also be or become a perpetrator of it, that is, acting both as victim and perpetrator, performing her actions in a context of 'bidirectional violence', hence, being 'at particularly high risk of developing mental health disorders'. There is evidence that women who experience IPV are more likely to physically abuse their children than women who do not experience abuse[46]. In this sense, it must also be observed how it can occur the phenomenon of 'displaced aggression', in which women who are victims of IPV or have no socio-economic conditions to actively resist against inequitable gender attitudes in their communities take out their rage, frustrations, and aggression on their own children through corporal punishments (*wrongly* taken as a way to exert discipline or control over subordinate members of her family), that reinforce the settling of an intergenerational cycle of violence.

Moreover, the potential impacts of sexual assault on women, as described in the psychological literature, are substantial, and generally include increased levels of anxiety, depression, posttraumatic stress disorder (PTSD), suicidality, dissociation, substance abuse, sexual disturbance, and negative self-perceptions[47].

Furthermore, according Goodson & Hayes (2018)[48] 'descriptive findings revealed [that] 34.88% of IPV victims engaged in help-seeking behaviors and the majority of victims who sought help reached out to family members (63.10%); Few IPV victims (3.24%) sought help from formal institutions'. Hence, it becomes highlighted the fundamentality of health professionals to proactively, intuitively, technically, and professionally seek to address observable or felt traits in the personality of the consulted woman, and characteristics of the environment in which she is immersed, that lead the professional to gather suspicions on the nature of her wounds, complaints, silences, avoidances, justifications, excuses, for all these aspects combined serve to analyse (analyze) whether her temperament, behaviour (behavior), and/or expression of ideas indicate possibilities of her being a victim, a perpetrator, or both within her interpersonal relations.

On the other hand, in the context of safeguarding children, it is extremely important to bear in mind that trauma that derives from interpersonal relations in the household – violence, neglect, abuse – is prone to acquire a chronic status within the family dynamics, and regularly threat the child's attempts of reaching and/or maintaining psychophysical integrity. This happens in a manner that prevents the child from reaching out for external help, for when she/he becomes somehow aware of the abnormality and dysfunctionality of the behaviours (behaviors) and narratives that compose her/his family nucleus, she/he is already so gravely disorganised (disorganized) cognitively, emotionally, and behaviourally (behaviorally) in her/his daily functioning that she/he tends to react with extreme helplessness, confusion, withdrawal, or even rage in dealing with her inner and external realities, what leads her/him to approach the topic of victimisation (victimization) possibly with the utmost silence and isolation, specially (trocar por *mainly*) because she/he relies emotionally and psychologically in the abuser for her/his own survival [the child is a dependent of the family-member, and has the latter as someone who was meant to love and protect her/him, but instead this 'love and protection' come in the form of sadistic violence

against her/him]. The unbearable sadness and anxiety that comes from this context contributes for making extremely difficult for these children to regulate their own affects and emotions, what can lead them to exhibit behaviours (behaviors) such as 'aggressiveness against oneself (e.g., self-mutilation, head banging) and others, distrust of others, dissociative behaviors, attention and concentration difficulties, mood swings, and impulsivity (Cullerton-Sen et al. 2008; De Sanctis et al. 2008; Glassman et al. 2007; Price et al. 2013)' (p. 278)[49].

By reaching the age, and/or developmental stage in which there are more engaged participation within webs of community and/or social support – what promotes self-agency –, the child, as a social actor, gains access to deeper, and more comparative comprehension of information, what creates the possibility for a more logical ability to decodify meaning. Hence, through her own development within these external networks, the child, hopefully and gradually, reaches perspectives from which she/he can cognitively process that what is in practice within her/his own family deviates from expected and good-enough patterns of facilitating and supporting biopsychosocial growth [however, sometimes *unfortunately* her own condition just replicates as if the 'cultural norm of a society]. Nevertheless, by being a victim of intolerable violence and violation, it can happen that – correlated or not with a serious dissociation in the personality that makes the memories of the abuse [or of the accumulation of events of abuse] to be repressed, forgotten, disorganised (disorganized), or denied – maladaptive mechanisms of understanding and coping with the intrinsically non-understandable and emotionally highly stressful relationship she/he has with perpetrators (parents, caregivers, and/or siblings) such as self-blaming or self-responsibilisation (self-responsibilization) can be activated.

These, accumulated and reproduced daily in the self-talk the child engages with herself/himself within the reality of lack of safety and support that marks the home environment. Other maladaptive ways that children present for dealing with the violence to which they are subjected involve the expression of:

> rigidly controlled behavior patterns such as inflexible rituals, compulsive compliance with requests from adults, and rigidly controlled eating habits (Johnson et al. 2002; Lochner et al. 2002; Spinazzola et al. 2005) [...], behavioral reenactments of their traumatic experience through aggression (Cullerton-Sen et al. 2008),

> sexualized behaviors (Kendall-Tackett et al. 1993), self-injurious behaviors (Noll et al. 2003), and frozen avoidance reactions (e.g., dissociation; Macfie et al. 2001) (p. 278)[49].

In comprehending all the seriousness of and interrelation between violence against women and the possibility this violence has of being handed down, as if unconsciously, to the inadequate caring women can offer to their children is that, when the professional has a suspicion over women's victimisation (victimization), based on reasonable grounds, it would be recommendable to him/her not only to pedagogically inform these women on the nature, risk, patterns, and consequences of abusive interrelationships; but to refer them to expert support, signalising (signalizing) to them where to encounter free legal advice, charity organisations (organizations) that deal with their specific necessities, and/or offer them access to their local women's aid.

In relation to children, for them being minors, the professional must be bolder in her/his detection and response measures, and by informing oneself whether there is a mandatory reporting law, that is, a statutory duty imposed on her/him in his/her local jurisdiction to report suspected cases of designated types of child maltreatment to child welfare agencies, she/he is obliged to report known and suspected cases to government welfare agencies. According to Mathews (2014)[50], it is also essential to analyse (analyze) that not all manifestations of harm are treated by the laws as 'abuse', however:

> Sexual abuse is an exception to this, as all sexual abuse is seen as having such seriousness as to merit some kind of response. For the other three maltreatment types [physical or psychological abuse, neglect], the reporting duties are targeted at instances of abuse or neglect which have already been of sufficient severity to cause serious harm, or to involve acts which have already been committed which may not yet have caused such harm but present an imminent risk or likelihood of causing such harm (Ibid., p. 463).

Another aspect that leaves health professionals in doubt whether to make a formal report or not in relation to their analysis of children who they suspect suffer from

maltreatment refers to the interpretation of the concept of 'reasonable suspicion' that permeates the decision to exert a mandated reporting. Levi et al. (2011) clarify that:

> (a) suspicion is best understood as a feeling (that child abuse may have occurred) rather than a belief (ie, holding an idea to be true) and (b) reporting practices might benefit from guidelines that stipulate the percent probability (25%, 75%, or something in between) that should trigger reporting of suspected child abuse [being that this percent probability refers to the percentage/level of likelihood the professional feels while considering whether abuse is the most likely explanation for the clinical scenario she/he is investigating] (Ibid., p. 326).

In cases in which there is the legally mandated necessity of reporting child abuse, and reasonable suspicion to do it so, the professional must report her/his observations and impressions of a case to a police official, a local/provincial department of social development/care or any other formally designated child protection organisation (organization), hence, she/he can be ensured that the child will be safe, the abuse will stop, rehabilitation will be provided, and the needs of the child and the family will be analysed (analyzed) and supported, in a timely manner.

**Recommendations on structural interventions**

The public health experts have a vital role to play in networking with Non-government organizations (NGOs) and voluntary organizations and creation of social support networks[51] and statutory interventions must be designed and implemented in collaboration with women and children-violence voluntary and/or informal victims-organisations (organizations). Recommendations from the authors include: a) payment of financial benefits and social protection for all women and children at risk of vulnerability including migrants with illegal or uncertain residency status; b) provision of emergency housing to those who are homeless, moratorium on evictions, and assistance with rent or mortgage repayments; c) divulgation of health promotion advice on prevention of COVID-19 with language translation; d) maintenance and extension of person-centred (centered) services to address needs associated with mental health, physical and sexual violence; e) specifically train mental health professionals to support individuals in their specific necessities during the pandemic,

by providing first-line psychological support, enquiring about needs and concerns, validating individuals' experiences and feelings, enhancing safety, and referring these individuals to relevant support services[21]; f) the development and divulgation of prevention policies and school-based strategies to prevent child sexual abuse focused on improving children's understanding of their bodies, appropriate and inappropriate touch, also teaching them who they could address if they had concerns about someone's behavior[52].

**Final considerations**

Precise biological details about the COVID-19 disease are under scrutiny but social effects have clearly surfaced as collateral issues. It is important to note that the incidence of the pandemic started at different times in different countries and, therefore, worldwide cases of child abuse, domestic violence and feminicide may increase. Despite the fact that the pandemic has brought up more suffering and fear in the world, the consequences of that might accelerate the elaboration and implementation of public measures on decision making involving vulnerable women and children.

## Conflict of interest

The authors declare no conflict of interest.

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